Columbia County Report of Work Injury, Incidents and Accident Investigations

Supervisor to Complete, Sign and Deliver this original to the Human Resources Department within 24 hours of the event.

Section A: To be completed by the Supervisor

Employee=s Name _____

Date of Injury_____ Time_____ Date Reported_____

Time Workday Began_____ Normal Work Schedule_____ (Mon-Fri, Shift,etc.)

Did employee work following day? _____ If not, was cause due to accident or shift?_____

Returned to work_____ Location of incident_____

Nature of Injury and part of body affected **BE SPECIFIC_____

_____

_____

Sheriff=s Office or Police Department Case # _____ (If applicable. Attach a copy of the report to this form)

Did this incident involve possible exposure to infectious agents or pathogens?_____

Section B: Treatment

____No apparent injury

____Minor First Aid Only

____Hospital or Emergency Care ----------

Transported by_____

____Fatal Injury

____Disabling Injury

____Potential Permanent Injury

Work Hours Lost day of injury_____

Total Lost time hours_____

Medical Treatment Offered?_____

Medical Treatment Accepted?_____

Medical Treatment Refused? _____

Employee=s Signature_____

Attach Medical Treatment Paperwork to this form!

Section C: Details of injury by Supervisor and/or Witnesses: (Be Specific on the facts leading to the Injury)
Use additional pages as necessary.

_____

_____

_____

_____

_____

_____

List all property involved (include: Description & Serial #, Current location, Owner, and Extent of Damage).

_____

_____

_____

Names and addresses of any others involved in this incident: _____

_____

_____

_____

Supervisor=s Name_____Signature_____ Date_____

Original to Human Resources Department
A separate form will be provided for Liability Claims from Risk Management

PART I EMPLOYEE ELECTION STATEMENT

Workers= compensation benefits entitle injured employees to compensation for lost wages due to a compensable work-related injury. Georgia state law mandates that the employer or its insurer must pay an injured worker 66 2/3% of his/her average gross weekly wage for the duration for his/her disability. State law designates a waiting period of seven calendar days of disability before income benefits are payable. However, should the injured employee remain disabled from employment for 21 calendar days, then the first seven days of disability(waiting period) would become compensable to the injured employee.

As an injured employee of Columbia County you have the option of using part or all of your accrued sick or vacation time. However, any sick or vacation time that is used will not be reimbursed by the county=s workers= compensation carrier/servicing agent. Should you elect not to use any accrued sick or vacation time, you will be compensated for any period of disability under statutory workers= compensation benefits.

I have read and understand the above. I elect to utilize the following options in lieu of statutory Work Comp benefits:

1. _____ Elect to utilize a portion of my accrued sick time in lieu of statutory workers= compensation benefits.

2. _____ Elect to utilize a portion of my accrued vacation time in lieu of statutory workers= compensation benefits.

3. _____ Elect to utilize all of my accrued sick time in lieu of statutory workers= compensation benefits.

4. _____ Elect to utilize all of my accrued vacation time in lieu of statutory workers= compensation benefits.

5. _____ Elect **not** to utilize my accrued sick or vacation time and elect to utilize statutory workers= compensation benefits.

_____ _____ _____

Signature of Employee Signature of Witness

_____ _____

Date Date

****

PART II RELEASE TO RETURN TO WORK

Returned to work on:_____

Month Day Year

_____ _____

Date Signature of Supervisor

Attach Medical Release statement to this form. Forward to HR Department